Kansas Department on Aging

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLI	ΞΤΕD
		N059017	B. WING		03/1	7/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
ANGEL A	RMS	1318 OAKL				
		MCPHERS	ON, KS 67460			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS		S 000			
	The following citation: Licensure Resurvey a Residential Health Ca Kansas on 3/15/16, 3 Amended 2567 sent to	at the above named are Facility in McPherson, 3/16/16, and 3/17/16.				
S 230 SS=E	26-39-102 (b) (c) Admission Advanced Directives Resident Rights		S 230			
	shall inform the residerepresentative, in writerelated to advance medical direstance in the resident 's (2) The administration of polyrelated to advance medical direstance medical directance medical dire	an advance medical directive e facility shall keep a copy on clinical record. In rator or operator, or the re the development and licies and procedures edical directives. In or operator, or the rede a copy of resident rights, as policies and procedures for ectives, and the adult care licy to each resident or the sentative before the				
	This REQUIREMENT by: KAR 26-39-102(b)(c)	is not met as evidenced				
	three Residents. Base	13 the sample included ed on interview and review hree sampled (#189 and ailed to ensure the				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

STATEMENT OF DEFICIENCIES (X) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		N059017	B. WING		03/1	03/17/2016	
NAME OF PI	ROVIDER OR SUPPLIER		RESS, CITY, STA	TE, ZIP CODE			
ANGEL A	RMS	1318 OAKL MCPHERS	.ANE ON, KS 67460				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE	
S 230	Continued From page	÷ 1	S 230				
	that specified if a Res directive currently in e	cility policies and procedures sident has an advanced effect, the facility shall esident's advanced directive.					
	Findings included:						
	facility 10/05/15 with of Hypertension, Cerebriside hemiparesis, and The electronic medical page documented "Fut A notation at the botton administration record! March 2016 notated "A paper list of Reside main kitchen cupboar reference in the event documented #187 as The medical record lawith Resident/Legal Fisignature. The medical record lawith medic	om of each MAR (medication) from October 2015 to 'DNR" (do not resuscitate). ent names taped inside the rd, for immediate staff t of an emergency, "DNR". acked a DNR form, complete Representative or physician acked a legal document to discussed and actually the					
	On 3/15/16 at 2:00pm #C confirmed no copy available in the medic office in process of be On 3/16/16 at Operate confirmed no copy of DNR available state	n, Facility Licensed Nurse y of a DNR document cal record, or at the main					

NOS9017 STREET ADDRESS, CITY, STATE, ZIP CODE ANGEL ARMS SUMMARY STATEMENT OF DEPTICIPACIES PREFIX FREETY TAG SUMMARY STATEMENT OF DEPTICIPACIES PREFIX FREETY TAG CONTINUED FROM INSTITUTE OF DEPTICIPACIES PREFIX TAG CROSS-REFERENCED TO THE APPROPRIATE OFFICIANCY OFFI OFFI TAG S 230 Continued From page 2 Operator/RN #B provided copy of information given to Resident at time of admission. This page titled Advance Directives specified facility has policies to ensure Resident wishers followed (frem III) and specified the facility to maintain a copy of any advanced directive in Resident's record (item IV). The Operator/RN failed to ensure the implementation of facility policies and procedures that specified if #187 had an advanced directive currently in effect, the facility shall maintain a copy of Resident's advanced directive in the medical record revealed #189 admitted to facility 01/25/11 with diagnoses of Diabetes II and Dementia. The medical record contained forms (negotilated service agreements, service agreements, etc) signed by persons other than the Resident. Initially, unable to locate the DNR form signed by Resident and physician. On 3/16/16 at 10-16am, Operator/RN (registered nurse) #8 continued #189 has a "DNR" a DPOA (durable power of attorney) and a DPOA for Healthcare, #8 able to locate the "DNR" form. The medical record still lacked the DPOA and DPOA for Healthcare documents, #8 contacted family members and requested these be faxed immediately to facility. On 3/16/16 at 1-10pm.	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	1 ' '	(X3) DATE SURVEY COMPLETED	
ANGEL ARMS SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG PROVIDER'S PLAN OF CORRECTION PROPERTY TAG PROVIDER'S PLAN OF CORRECTION PROVIDER'S PLAN OF CROSS PLA			N059017	B. WING		03/1	7/2016	
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) S 230 S 230 Continued From page 2 Operator/RN #B provided copy of information given to Resident at time of admission. This page titled Advance Directives specified facility has policies to ensure Resident wishes followed (item III) and specified the facility to maintain a copy of any advanced directive in Resident's record (item IV). The Operator/RN failed to ensure the implementation of facility policies and procedures that specified if #187 had an advanced directive currently in effect, the facility shall maintain a copy of Resident's advanced directive in the medical record. - Review of record revealed #189 admitted to facility 01/25/11 with diagnoses of Diabetes II and Dementia. The medical record contained forms (negotiated service agreements, service agreements, etc) signed by persons other than the Resident. Initially, unable to locate the DNR form signed by Resident and physician. On 3/16/16 at 10:16am, Operator/RN (registered nurse) #B confirmed #189 has a "DNR" a DPOA (durable power of attorney) and a DPOA for Healthcare documents. #B contacted family members and requested these be faxed immediately to facility. On 3/16/16 at 1.44pm,			1318 OAKL	ANE				
Operator/RN #B provided copy of information given to Resident at time of admission. This page titled Advance Directives specified facility has policies to ensure Resident wishes followed (Item III) and specified the facility to maintain a copy of any advanced directive in Resident's record (Item IV). The Operator/RN failed to ensure the implementation of facility policies and procedures that specified if #187 had an advanced directive currently in effect, the facility shall maintain a copy of Resident's advanced directive in the medical record. - Review of record revealed #189 admitted to facility 01/26/11 with diagnoses of Diabetes II and Dementia. The medical record Resident profile page documented "DNR." The medical record contained forms (negotiated service agreements, etc) signed by persons other than the Resident. Initially, unable to locate the DNR form signed by Resident and physician. On 3/16/16 at 10:16am, Operator/RN (registered nurse) #B confirmed #189 has a "DNR" a DPOA (durable power of attorney) and a DPOA for Healthcare. #B able to locate the "DNR" form. The medical record still lacked the DPOA and DPOA for Healthcare documents. #B contacted family members and requested these be faxed immediately to facility. On 3/16/16 at 1.40pm,	PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR	BE	COMPLETE	
Operator/RN #B confirmed the DPOA and DPOA for Healthcare arrived by fax.	S 230	Operator/RN #B provigiven to Resident at titled Advance Directive policies to ensure Resill) and specified the of any advanced direct (item IV). The Operator/RN failed implementation of fact that specified if #187 currently in effect, the copy of Resident's addirect medical record. - Review of record rest facility 01/25/11 with of Dementia. The medical record Reservice agreements, signed by persons of the Initially, unable to local service agreements, signed by persons of the Initially, unable to local Resident and physicial (durable power of atto Healthcare. #B able to The medical record sidned proposed for Healthcare family members and remediately to facility Operator/RN #B confirmed and immediately to facility Operator/RN #B confirmed family members and remediately to facility Operator/RN #B confirmed family members and remediately to facility Operator/RN #B confirmed family members and remediately to facility Operator/RN #B confirmed family members and remediately to facility Operator/RN #B confirmed family members and remediately to facility Operator/RN #B confirmed family members and remediately to facility Operator/RN #B confirmed family members and remediately to facility Operator/RN #B confirmed family members and remediately to facility Operator/RN #B confirmed family members and remediately to facility Operator/RN #B confirmed family members and remediately to facility Operator/RN #B confirmed family members and remediately to facility Operator/RN #B confirmed family members and remediately to facility Operator/RN #B confirmed family members and remediately to facility Operator/RN #B confirmed family members and remediately to facility Operator/RN #B confirmed family members and remediately to facility Operator/RN #B confirmed family members and remediately to facility Operator/RN #B confirmed family members and remediately to facility Operator/RN #B confirmed family family members and remediately family	ided copy of information ime of admission. This page was specified facility has sident wishes followed (item e facility to maintain a copy ctive in Resident's record ed to ensure the sility policies and procedures had an advanced directive e facility shall maintain a dvanced directive in the example of the facility shall maintain a dvanced directive in the example of the facility shall maintain a dvanced directive in the example of the facility shall maintain and facility	S 230	DEFICIENCY			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		N059017	B. WING		03/17/2016
NAME OF P	ROVIDER OR SUPPLIER	1318 OAI	DDRESS, CITY, STA KLANE SON, KS 67460	ΓΕ, ZIP CODE	
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S 230	that specified if #187 currently in effect, the		S 230		
\$3092 \$\$=E	Revisions (d) Each administrato the review and, if neonegotiated service ag following requirement 365 days; (2) following any signias defined in K.A.R. 2 (3) at least quarterly, assistance with eating assistant; and (4) if requested by the legal representative, finanager, or, if agreed	if the resident receives g from a paid nutrition e resident or the resident 's	S3092		
	by: KAR 26-41-202(d)(1)(The census equalled three Residents. Base interviews, and review sampled (#187 and # ensure the review and each negotiated servi	13 the sample included ed on observation, ws of record, for two of three 185), the Operator failed to d if necessary revision of ce agreement (NSA) if ident or the Resident's			

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING: _		COMPLI	ETED
			B. WING			
		N059017	D. WING		03/1	7/2016
NAME OF P	ROVIDER OR SUPPLIER		RESS, CITY, STA	TE, ZIP CODE		
ANGEL A	RMS	1318 OAKL MCPHERS	.ANE ON, KS 67460			
(V4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECTION	N	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	COMPLETE DATE
S3092	Findings include: - Review of record revealed #187 admitted to facility 10/05/15 with diagnoses of Diabetes II, Hypertension, Cerebrovascular accident with Left hemiparesis, and Multi-infarct dementia. The current 10/06/15 functional capacity screen (FCS) assessed #187 in need of physical assistance with bathing, dressing, toileting, transfers, and mobility; unable to manage medications and treatments; with cognitive		S3092			
	impairment; with falls	<u> </u>				
	The current 10/06/15	negotiated service				
	-	cumented #187 to receive nese needs from facility.				
	Inter Office Communi revealed:	cation (IOC) notes of record				
		late entry from 10/09/15 had I 1030 was trying to get up f end of foot rest				
	•	nome health nurse came nt on both fallscombative				
	interventions last revi family reinforced wi	th #187 importance of using or transfer reviewed with				
	interventions reviewe	had fall on 12/05/15 fall d, will now have pressure all times to help prevent				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:	
		N059017	B. WING		03/17/2016
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STA	TE, ZIP CODE	
ANGEL A	RMS	1318 OA MCPHEF	KLANE RSON, KS 67460		
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S3092	Continued From page	: 5	S3092		
	future falls				
	waiting for staff assist	nt completed no discussed importance of ance			
	02/29/16 - 4:59pm - Resident had fall on 02/27/16 see home health chart for fall assessment and fall follow up Review of the NSA revealed the added interventions of a motion alarm on 11/02/15, a pressure pad underneath on 12/06/15, and ongoing education about waiting for assistance, not on the current NSA. The medical record lacked any NSA addendums.				
		o ensure the review and or #187 when changes in changes in services.			
	facility admitted 01/07 Congestive heart failu	th behavior disturbances,			
	The current 01/07/16 (FCS) assessed #185 assistance with bathir transfers, and mobility medications and treat impairment; and with	ng, dressing, toileting, y; unable to manage ments; with cognitive			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	CONSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING: _	A. BUILDING:		EIED
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S3092	The current 10/06/15 negotiated service agreement (NSA) documented #185 to receive services to address these needs from facility. Inter Office Communication (IOC) notes of record revealed: No entries or documentation for admission of Resident to facility. 01/11/6 - 2:44pm - follow-up from fall on 01/10/16 assessment completed treatment provided staff education on checking Resident more frequently when in bed and using pressure pad, and responding to alarm in timely manner Resident education on using call light and waiting for staff assistance before standing or ambulating		S3092			
		follow-up from fall on wheelchairconfused estions appropriately				
		all placed to physician in all awaiting return call at				
	night shift Resident noted family notified	patient had two falls during assessed bruised area d staff educated on Resident while in bed to				
	•	all interventions reviewed, into place due to Resident's				
		evealed the interventions of a rm, and staff responding in				

Nansas L	repartment on Aging					
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	URVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	ETED
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		N059017	B. WING		03/1	7/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE ZIP CODE		
		1318 OAKL		,		
ANGEL A	RMS					
		MCPHERS	ON, KS 67460			1
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
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S3092	Continued From page	e 7	S3092			
	time als / ma a m m a m a m 0.4 /	44/4C - 21/2 m / 45 m in / 45				
	•	11/16, every 15 minute				
		and other new interventions				
		ot on the current NSA. The				
	medical record lacked	d any NSA addendums.				
		n, Operator/RN (registered				
	•	the NSA lacked revision or				
	addition of newly plan					
	address ongoing falls	s.				
		o ensure the review and				
	revision of the NSA for	or #185 when changes in				
	care needs prompted	l changes in services.				
S3228	26-41-205 (I) (3) Med	lication Regimen Review	S3228			
SS=F	Record	ileation regimen review	00220			
	record					
	(I) (3) The administrat	tor or operator, or the				
	designee, shall ensur					
		ot in each resident 's clinical				
	record.					
	This DECLUDEMENT	is not mot as suideneed				
		is not met as evidenced				
	by:					
	KAR 26-41-205(I)(3)					
	The conque court	12 the comple included				
		13 the sample included				
		ed on reviews of records				
	and interviews, for all residents, the Operator/RN					
		nedication regimen reviews				
	kept in each Resident	t's clinical record as				
	evidenced by review	two of two sampled (#189				
		with medication regimen				
	reviews.	<u> </u>				
	Findings included:					
	. J					

Nalisas L	repartifient on Aging					
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	ETED
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		N059017	B. WING		03/1	17/2016
NAME OF D		STDEET AS	DDEEC CITY CTA	ATE ZID CODE		
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STA	AI E, ZIP CODE		
ANGEL AI	RMS	1318 OAF	KLANE			
,		MCPHER	SON, KS 67460)		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON	(X5)
PREFIX	,	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL		COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROI	PRIATE	DATE
				DEFICIENCY)		
S3228	Continued From page	- R	S3228			
00220	Continued From page	5 0	00220			
	- By review of Reside	ent Roster, all Residents of				
	facility received medication and treatment management services.					
	- By interview on 3/1	6/16 at 10·29am				
		red nurse) #B stated the				
		st comes to facility every				
		nacist sends me an email				
	•					
	after each visit that lis					
	reviewed, and a general recap of his/her					
	•	nothing in individual charts				
	unless specific recom					
		eports) stated pharmacist				
	reviewed medications	s of all Residents 12/23/15,				
	email report includes	names of all Residents				
		for the individual medical				
	records provided.					
	#189 admitted to faci	lity 01/25/11 with diagnoses				
	of Diabetes II and De	-				
	9/09/15 functional cap					
		le to manage medications				
	and treatments.					
	_	ervice agreement (NSA)				
		receive these services from				
	facility.					
	#187 admitted to faci	lity 10/05/15 with diagnoses				
	of Diabetes II, Hypert	tension, Cerebrovascular				
	accident with Left her	miparesis, and Multi-infarct				
	dementia.	•				
	10/06/15 functional capacity screen (FCS) assessed #187 unable to manage medications					
	and treatments.	io to manage medications				
		convice agreement (NCA)				
	_	service agreement (NSA)				
		receive these services from				
	facility.					
	By review, each of the	ese records lacked an				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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S3228	Continued From page 9		S3228		
	individual drug regime	en review.			
	For all residents, the ensure the medication each resident's clinical	regimen reviews kept in			
S3261 SS=E	26-41-105 (f) (11) Res Documentation of Inci		S3261		
	and other indications	n of all incidents, symptoms, of illness or injury including rrence, action taken, and			
	This REQUIREMENT by: KAR 26-41-105(f)(11)	is not met as evidenced			
	three Residents. For t (#189, #187, and #18 ensure each Resident documentation of all in	ncidents, symptoms and ness or injury, including the			
	Findings included:				
		vealed #189 admitted to diagnoses of Diabetes II and			
	The current 9/09/15 fu (FCS) assessed #189 assistance with bathir				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE S	
AND FLAN	OF CORRECTION	IDENTIFICATION NOWIBER.	A. BUILDING: _		COMPL	EIED
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S3261	services to address the Inter Office Community revealed: 03/15/16 - 12:55pm - fall this AM, see HH (is assessment, family not physician notified via The medical record later and time of occurrence an assessment of the action taken, and results of the action taken, and results to include time discovered #189, allefall, actions taken, and taken. The Operator/RN failed contained documentate date, time of occurrence results of the action. Review of record refacility 10/05/15 with the Hypertension, Cerebrate hemiparesis, and Multiple and the services of the action.	regotiated service cumented #189 to receive nese needs from facility. cation (IOC) notes of record Resident had a non injury home health) for otified 0809 via phone call, fax acked documentation of area the record lacked ults of the actions taken. m, Operator/RN (registered the medical record lacked to of occurrence, who ged or determined cause of d results of the actions ed to ensure #189's record action of all incidents, the nee, action taken, and evealed #187 admitted to diagnoses of Diabetes II, ovascular accident with Left ti-infarct dementia. functional capacity screen	S3261			
	assistance with bathir					

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S3261	services to address the Inter Office Communication revealed: 10/10/15 - 10:46am - 10:	right with cognitive and with wandering. Inegotiated service cumented #187 to receive nese needs from facility. Ineaction (IOC) notes of record Itate entry from 10/09/15 had 1030 was trying to get up fend of foot rest Inatient has 2 falls the nome health nurse came not on both fallscombative Itesident had 3 falls since ewed meeting with the #187 importance of using for transfer reviewed with the even at all times Inhald fall on 12/05/15 fall did, will now have pressure all times to help prevent Interest of the prevent of the fall on the completed no discussed importance of the fall on the completed Resident had fall on fall on the completed	S3261			
	assessment and fall for					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE	
S3261	Continued From page 12		S3261				
	On 3/16/16 at 1:55pm, Operator/RN (registered nurse) #B confirmed the medical record lacked details to include times of occurrences, who discovered #187, alleged or determined causes of falls, actions taken, and results of the actions taken. The Operator/RN failed to ensure #187's record contained documentation of all incidents, the date, time of occurrence, action taken, and results of the action. - Review of record revealed #185 admitted to facility admitted 01/07/16 with diagnoses of Congestive heart failure, History of falling, Vascular dementia with behavior disturbances, and Malignant neoplasm of prostrate. The current 01/07/16 functional capacity screen (FCS) assessed #185 in need of physical assistance with bathing, dressing, toileting, transfers, and mobility; unable to manage medications and treatments; with cognitive impairment; and with falls.						
		negotiated service cumented #187 to receive hese needs from facility.					
	Inter Office Communi revealed:	ication (IOC) notes of record					
	No entries or docume Resident to facility.	entation for admission of					
		llow-up from fall on ent completed treatment cation for prevention of					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		` ′	(X3) DATE SURVEY COMPLETED			
		N059017	B. WING		03/1	7/2016			
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TE, ZIP CODE					
ANGEL ARMS 1318 OAKLANE MCPHERSON, KS 67460									
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE			
S3261	Continued From page 13		S3261						
	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)								